Going Further:

Building on *A Framework for Reform*

September 2002

Committee on Collaboration and Innovation

alberta
HEALTH FIRST

"Alberta's health system

is complex and diverse. It's an interwoven web where decisions or actions in one part of the system have a profound effect on others. It's wrapped up with emotional debates, dedicated professionals, long standing traditions, old biases clashing with brand new ideas. And because it potentially affects all of us at some time in our lives, we can't look at it dispassionately.

"In the midst of the debate and discussion, we should not forget that there is much to be proud of in Alberta's health system. It is staffed and led by dedicated and outstanding health providers and administrators. We have some of the best health authorities in the country. We provide leading edge treatments and technologies. Alberta is known as a national and international leader in health research. People who receive care rate it highly. There are thousands of babies born, surgeries performed, home care visits provided to older people in their homes, immunizations, visits to doctors, and inspections of restaurants each and every day."

A Framework for Reform, Premier's Advisory Council on Health, page 1.

Letter *from the* Committee

September 2002

Health reform is a series of steps that will transform Alberta's health system over time, while maintaining what we value. This report is one of the steps in the reform process as Alberta moves to a more sustainable and responsive health system.

The Committee on Collaboration and Innovation was established in March 2002 as part of the Alberta Government's response to the Premier's Advisory Council on Health Report (Mazankowski Report).

Our mandate was to help transform the way health regions provide services and how the government and regions collaborate to provide those services.[1] This has been done to the best of our ability in the time we had and our recommendations can help change the way health services are provided. As this report was being finalized, work already is underway in some of the areas the committee reviewed. There are other innovative and collaborative ideas that the committee didn't have time to explore, which will emerge as the health system moves forward.

A positive mix of expertise on the committee has aided our work, with members drawn from the Legislative Assembly, officials within Alberta Health and Wellness, chairs and CEOs from the health regions and a member of the reform implementation team. This configuration worked well, as members shared their perspectives and knowledge and built on each other's expertise.

Many talented people also supported the Committee, including very knowledgeable senior officials within the health regions and Alberta Health and Wellness. We all owe them a debt of gratitude.

[1] Recommendation five of the Premier's Advisory Council on Health was our starting point, with the exception of the recommendation to integrate mental health services with the work of the health authorities.

Committee Members

Drew Hutton, Committee Chair
MLA Edmonton Glenora

Mary Anne Jablonski
MLA Red Deer North

Don Tannas
MLA Highwood

Jack Ady, Chair
Chinook Health Region

Ed Andersen, Chair
Council of Chairs of Health Authorities
Chair, East Central Health Region

Bob Cable, CEO
Aspen Health Region

Jack Davis, CEO
Calgary Health Authority

Tom Seaman, Chair
Council of CEOs of Health Authorities
CEO, Palliser Health Region

Sheila Weatherill, CEO
Capital Health Authority

Jeanette Pick, Member
Health Reform Transition Team

Wendy Hassen, Assistant Deputy Minister
Alberta Health and Wellness

Bruce Perry, Assistant Deputy Minister
Alberta Health and Wellness

Alex Stewart, Assistant Deputy Minister
Alberta Health and Wellness

Recommendation Five

Reconfigure the health system and encourage more choice, more competition and more accountability.

A Framework for Reform, Premier's Advisory Council on Health, page 48

Table of Contents

page

Overview

- Next Generation Health Authorities . . . 5
- Figure One – Transforming Health Authority Service Delivery . . . 6

Key Themes

- Accountability . . . 7
- Performance and Outcomes . . . 7
- Collaboration . . . 7
- The Role of Health Care in the Economy . . . 7
- New Models of Care . . . 7
- Technology . . . 8
- Purchasers and Providers of Service . . . 8
- Cost Management and Revenue Generation . . . 8

Scope of Recommendations . . . 9

Health Roles and Responsibilities for the Government of Alberta and Health Authorities . . . 10

Multi-Year Performance Contracts . . . 14

Facilitating Collaboration and Developing New Models of Care . . . 18

- Facilitating Collaboration . . . 18
- Joint Programming and Cross-Boundary Service Delivery . . . 20
- Information Technology . . . 22
- Human Resources and Expanded Scope of Practice . . . 25
- Continuing Care . . . 27
- Primary Health Care Models . . . 30
- Acute Care . . . 33

Establishing Centres of Specialization . . . 35

Contracting with a Blend of Providers . . . 38

Appendix One:

Key Deliverables and Performance Measures Framework . . . 42

Appendix Two:

Guiding Principles for Collaboration and Unique Factors for Consideration . . . 47

Overview

As the Premier's Advisory Council on Health said, "If we're going to have regional health authorities, and we should – then it's time to give them the mandate and the tools to allow them to do the job and hold them accountable if they don't." (*A Framework for Reform*, page 7.)

Much has been done to rationalize and integrate services since 1994 when the health regions were first established. Further changes to the role and actions of the health authorities are being proposed in this report and other parts of the health reform process.

The Committee on Collaboration and Innovation believes the cumulative impact of the reforms will be an evolutionary shift to 'next generation' health authorities. As recommendations are implemented, next generation health authorities will be given more responsibility for determining how services are delivered and will be more accountable for their actions.

These next generation health authorities will be empowered, accountable, and collaborative. They will be guided by an overall framework for health services in Alberta that sets clear guidelines for core services, service standards and access. They will be responsive to the needs of the people they serve. They will be contractors as well as providers of health services; and as managers of much of the health system, they will have province-wide human resource strategies. These strategies will help ensure the system has the people it needs to deliver services and that the people working in health care are working to their new scopes of practice.

Alberta Health and Wellness will keep the vision and be a leader of health system innovation within Alberta and Canada, be accountable, set standards, enforce its contracts and keep its commitments, and be a major funder of health services.

And as a result, the health system should be more sustainable, patient oriented and fiscally responsible.

Figure one, on page six, illustrates the evolution that will take place as the reform process unfolds and recommendations from the Committee on Collaboration and Innovation and others are implemented.

Section 5, *Regional Health Authorities Act*, sets out the following responsibilities for health authorities:

i. Promote and protect the health of the population in the health regions and work towards the prevention of disease and injury.

ii. Assess on an ongoing basis the health needs of the health authority.

iii. Determine priorities in the provision of health services in the health region and allocate resources accordingly.

iv. Ensure that reasonable access to quality health services is provided in and through the health authority.

v. Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health authority.

Figure One: Transforming Health Authority Service Delivery

An overview of the evolution that will take place as the reform process unfolds and recommendations being made by the Committee on Collaboration and Innovation are implemented:

1. Roles and responsibilities of government and health authorities are clearly defined and understood.

2. Performance contracts set out the expectations for government and health authorities.

3. 'Next generation' health authorities carry out their responsibilities under the terms of performance contracts. They have adopted 'purchaser of service' practices. They are known for quality services, meeting or exceeding access objectives, ability to manage costs, increased patient choice and new models of service delivery.

Next generation health authorities report to the Minister of Health and Wellness and work with the department. They are accountable to the Government of Alberta and the people they serve.

Government sets the vision, provides funding and ensures performance.

Health authorities plan and ensure the delivery of services.

Performance contracts represent the mutual expectations and obligations of health authorities and government and replace three-year business plans.

The Committee on Collaboration and Innovation recommendations support and enable next generation health authorities:

Incentives to encourage collaboration, such as the proposed Collaboration Fund

Framework for health services that determines the core services, sets service standards and defines access

Centres of specialization

Technology

- IM/IT Plan
- Common standards
- Shared service arrangements
- Canada Health Infoway partnership

New models of service

- Primary care
- Hospital
- Continuing care
- Electronic Health Record (EHR)
- Telehealth
- HEALTHLink
- Expanded scope of practice
- Provincial formulary
- Business models

People plan for human resources

Integrated patient transport services

Enhanced capacity to purchase services

Collaborative business support services

Key Themes

Accountability

The recommendations on roles and responsibilities and work done on performances contracts will strengthen accountability as Alberta Health and Wellness focuses on its role as leader in the health system and health regions are able to more effectively ensure services are delivered.

Performance and Outcomes

We are recommending that multi-year performance contracts be reviewed by an independent third party such as the Auditor General and annual reports published by the Alberta Government. We are also recommending that outcomes and results be measured by an arms length organization such as the Health Utilization and Outcomes Commission.

The Committee is also recommending a streamlined number of measures that health authorities will be asked to report and monitor. Over-measuring and over–reporting draws organizational energy from other initiatives. We must measure in the health system, but measure what will make a difference to the operations of the system and health outcomes for Albertans.

Collaboration

Health authorities collaborate all the time and there are many examples of successful outcomes. More can be done. Guiding principles and factors to be taken into consideration have been set out by the authorities and will guide further action. The Committee also believes that the development of clear guidelines for service delivery based on access, appropriateness, patient safety and effectiveness will help regions and the public determine the best mix of services and delivery methods.

The Role of Health Care in the Economy

As the Premier's Advisory Council notes, the health system is a major driver in the Alberta economy. This is perhaps most keenly felt in rural Alberta, where it provides employment, attracts people and sustains the people already living in rural areas. The Committee is recommending the development of a rural health strategy and a framework that sets service standards and defines access to the health system. These will support better decision making and help all Albertans understand what they can expect from the system.

New Models of Care

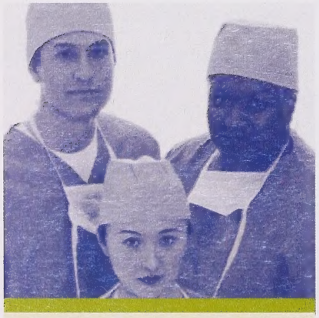
There are many exciting ideas for better ways to deliver services and innovation and new ways of thinking come naturally to the system. Better use of technology, making it possible for people to work to their scope of practice and developing new acute care delivery models can make a difference to the effectiveness and sustainability of the system.

> We can't regulate to perfection. It's time to open up the system, take the shackles off, allow health authorities to try new ideas, encourage competition and choice, and see what works and what doesn't.
>
> *A Framework for Reform,*
> Premier's Advisory Council on Health,
> page 5

Technology

The use of technology in health care is both exciting and frustrating due to the tremendous potential for delivering services more efficiently and effectively, but progress is slow. Alberta is at the cusp of real progress. By 2004, Alberta Supernet will provide broadband connections to all parts of Alberta, including health authorities. Strides are being made to automate physician's offices, including the establishment of electronic health records. Telehealth is already making a difference to people and providers across the province.

More needs to be done. Among others, the Committee is recommending a single, three year IM/IT plan, longer-term funding for information technology and implementation of new technologies in diagnostic imaging.



Purchasers and Providers of Service

Purchasing services is not new to health care in Alberta. However, the organizational challenges and significant resources required to move the system to one characterized by more choice and competition need to be acknowledged. Increasing choice and competition will require that health authorities shift their organizational cultures to a purchaser perspective from that of a provider. Health authorities will continue to deliver services, but where they do, it will be because it's the most effective option, rather than a continuation of the historic ways of doing things.

There are both benefits and risks involved in contracted services – services should be contracted out only when the community is better served by doing so. As well, if we want to encourage competition and choice, there need to be more participants in the marketplace to lower the potential costs and risks. Markets respond to opportunity and health authorities will need to work with providers to develop a strong, competitive marketplace where good options and opportunities exist.

Cost Management and Revenue Generation

Collaboration and innovation in the health system will result in better ways of delivering services, better use of health system resources including people and money, and better health outcomes. The work of the Committee on Collaboration and Innovation will integrate with the work of the Expert Advisory Panel to Review Publicly Funded Health Services and the MLA Task Force on Health Care Funding and Revenue Generation, with the former making recommendations on services and the latter providing options for raising appropriate revenue. All of this will help ensure a better managed, more efficient system that maximizes the value of public health spending.

Scope of Recommendations

The Committee reviewed and made recommendations in five areas:

- Roles and Responsibilities for the Government of Alberta and Health Authorities
- Multi-Year Performance Contracts
- Facilitating Collaboration among Health Regions and Developing New Models of Care
- Establishing Centres of Specialization
- Contracting with a Blend of Providers

This report focuses on health authorities and the role of government where health authorities are being set along a path that should encourage more choice and competition.

The health system also involves many other individuals and groups with critical roles in the reform process, including their relationships with health regions. In some areas, these other roles have been discussed with recommendations for change and further exploration. These are intended to be supportive of work being done every day in the health system: Doctors, nurses and other professionals, along with people in health administration, are critically important to the system and work very hard to ensure that Albertans have the services they need.

Priorities for Implementation

Those recommendations that the Committee believes can make the biggest difference to the health system and therefore should be the priorities for implementation are, in order:

- Adopting clear roles and responsibilities for government and health authorities.
- Establishing performance contracts between health authorities and Alberta Health and Wellness.
- Implementing primary care and new models of care, including the adoption of a single provincial formulary for drugs, acute recovery beds and hospital care teams.
- Removing the barriers to an effective continuing care system.
- New and renewed collaboration initiatives.

Section One:

Health Roles and Responsibilities for the Government of Alberta and Health Authorities[2]

The Government of Alberta and the province's health authorities are moving to performance contracts, as set out in the recommendations made by the Premier's Advisory Council on Health. These contracts will be the blueprints for services delivered by or through health authorities. Clear roles and responsibilities are the contracts' building blocks.

Clearly defined roles and responsibilities will:

- Help avoid costly duplication and make responsibilities clear.
- Set the groundwork for three-year performance contracts.
- Simplify the business plan requirements currently in place.
- Ensure that there is meaningful accountability.
- Ensure that health authorities are efficient and productive through meaningful measures.

The roles and responsibilities being recommended are clear, although they will require diligence in practice: Government sets the vision, provides funding and ensures performance; and health authorities plan and ensure the delivery the services.

Recommendation 5.1

Set out clear and distinct responsibilities for government and health authorities.

A Framework for Reform, Premier's Advisory Council on Health, page 48

There are other challenges, though, surrounding roles and responsibilities in Alberta's health system:

- The Alberta Government remains responsible for the direct delivery of several key services not transferred to health authorities during the initial move to regionalization in the mid 1990s. These include programs fundamental to the ability of health authorities to meet the needs of people within their jurisdiction, such as Alberta Aids to Daily Living.
- The Alberta Government delivers population health strategies such as tobacco reduction. At the same time, each health authority is responsible for improving the health of its population and manages the system of community health clinics that are instrumental in delivering many population health programs. This overlap in jurisdiction can distort and affect the priorities and programs of government and health authorities.
- Physicians are directly responsible for determining much of the care Albertans receive from health regions, yet the Medical Services Budget from which physicians are paid is managed through an agreement between Alberta Health and Wellness and the Alberta Medical Association. Health authorities, physicians and other stakeholders need to work together to develop new models of care and identify a mutual understanding of regional priorities.

[2]A draft of this section was originally submitted to the Minister of Health and Wellness, May 2002. That draft has been incorporated into this and other sections of the report.

Recommendation Will Lead To:

Recommendation 1.1

Better use of resources overall | Overall improved service to Albertans

The following broad roles and responsibilities should guide the actions of the Government of Alberta and the province's health authorities and become the guidelines for performance contracts between health authorities and Alberta Health and Wellness.

Government of Alberta Roles and Responsibilities

a. Alberta Health and Wellness will set the strategic direction for the provincial health system by:

- developing the overall vision, goals and objectives of Alberta's health system;
- developing province-wide standards and policy guidelines;
- setting priorities;
- developing legislative framework; and
- influencing health system reform nationally and being proactive in its relationships with the Government of Canada and other provinces.

b. The Alberta Government will allocate sufficient resources to health authorities to allow them to meet the strategic objectives set out in performance contracts, as well as allocating resources to other healthcare functions.

c. The Minister of Health and Wellness:

- enters into multi-year performance-based contracts with health authorities; and
- holds health authorities accountable for fulfilling their responsibilities.

d. Alberta Health and Wellness:

- prepares annual budgets and three-year targets for health services in the province, including funding that is consistent with multi-year contracts; and
- sets clear principles to guide decisions on new sources of revenue to support Alberta's health system.

e. Alberta Health and Wellness ensures that Albertans receive quality health services by:

- administering the Alberta Health Care Insurance Program and drug programs;
- enforcing the terms and conditions of performance contracts with incentives and remedies;
- ensuring health outcomes are achieved and performance is measured;
- providing information on health system performance to Albertans; and
- supporting health care and systems research.

f. Alberta Health and Wellness establishes provincial standards for information technology and ensures that the technology being used by health authorities is compatible throughout the health system so that information and data can be shared.

g. Alberta Health and Wellness leads the development and implementation of a provincial health workforce plan as it pertains to supply and demand, and supports the central role of faculties of medicine and health science faculties in conducting health research and training healthcare professionals.

Health Authority Roles and Responsibilities

Health authorities are responsible to manage health services within their region. In keeping with that responsibility, they should do the following.

a. Identify health needs and plan services and programs.

b. Determine how health services are delivered within their region:
   - purchase, contract or deliver health services; and
   - establish service agreements with providers, such as:
     - physicians;
     - groups of health providers;
     - clinics;
     - private surgical facilities;
     - private and not-for-profit organizations;
     - primary health care providers; and
     - other health authorities.

c. Integrate services and facilities within the health authority.

d. Establish collaborative service arrangements with other health authorities.

e. Enter into multi-year performance contracts with the Minister of Health and Wellness and develop business plans that are integrated with performance contracts.

f. Set priorities and allocate resources:
   - ensure programs and services are properly funded and meet performance objectives;
   - evaluate programs and measure outcomes, value and performance; and
   - optimize appropriate revenue opportunities in order to support service delivery in the region.

g. Report results to their region and to government.

h. Provide health information to people within their region.

i. Support and collaborate with post-secondary institutions to educate and train health providers.

j. Support clinical and health system research.

Recommendation Will Lead To:

Overall Cost Savings	Better use of resources overall	Overall improved service to Albertans

Recommendation 1.2

In order to move service delivery closer to the people who need the service, the following programs should be transferred to health authorities:

- Alberta Aids to Daily Living;
- STD/TB tracing; and
- the health information web site announced as part of the government's response to the Premier's Advisory Council on Health

Transfers of these programs and resources should be negotiated between government and health authorities.

Recommendation 1.3

Evaluative recommendation – not rated.

The following programs should be reviewed to determine if they should be transferred in part or wholly to health authorities:

- air ambulance services;
- ground ambulance services;
- Alberta Alcohol and Drug Abuse Commission;
- supportive housing;
- services to persons with developmental disabilities; and
- Provincial Laboratory Services.

Recommendation 1.4

Overall Cost Savings	Better use of resources overall	Overall improved service to Albertans

Alberta Health and Wellness needs to be given the lead role within government to plan and ensure an adequate supply of health workers, in order to best manage health workforce planning.

Workforce planning is one of the greatest challenges facing the health care system as the workforce ages and Alberta's population grows. Currently, several government departments share responsibility for workforce planning, including Alberta Learning and Alberta Human Resources and Employment.

Section Two:
Multi-Year Performance Contracts

The move to performance contracts is one of the most important shifts taking place in the health authority/government relationship, helping rationalize the planning process and improve accountability. Currently, health authorities submit three-year business and budget plans to Alberta Health and Wellness for approval by the Minister. Specific targets aren't set or agreed to and budgets are considered guidelines, making it difficult to put predictable plans in place. As well, the business plans have become complex documents used more to meet reporting requirements than as management tools. Multi-year contracts will provide greater stability and allow for better planning, but it is important to note that multi-year funding will also be important.

Performance contracts also will be a useful accountability tool. Accountability is complex in the health system. Health regions report to the Minister of Health and Wellness and work with the department of Health and Wellness. The Minister appoints board chairs and one-third of the board members and citizens residing in the regions elect the other board members. Performance contracts can help clarify the expectations of both the ministry and boards of directors and give the public a way to determine if their expectations are being met.

Recommendation 5.2

Establish multi-year contracts between the province and health authorities setting out performance targets to be achieved and budgets to be provided.

A Framework for Reform, Premier's Advisory Council on Health, page 49

The Committee has not set out to draft a legal document or structure. Rather, underlying issues and a framework for mutually beneficial contracts have been identified. Health authority deliverables and ministerial commitments will be the core elements of the performance contracts and performance items will change over time as health system and public priorities evolve.

One of the issues yet to be resolved involves setting out incentives and remedies. Remedial action plans should be required when a review and regular reporting indicate a problem. The plan's implementation should be closely monitored.

Recommendations

Recommendation Will Lead To:

Recommendation 2.1

Better use of resources overall | Overall improved service to Albertans

The following broad overriding guidelines need to be recognized and observed in the creation of multi-year performance contracts.

- Performance contracts should be recognized as government's primary approval mechanism for health authority funding and activities.
- Performance contracts must reflect the mutual accountabilities of both Alberta Health and Wellness and health authorities.
- Performance contracts are negotiated documents agreed to by both parties.
- Performance contracts should include three elements:
    - principles and assumptions;
    - ten to 15 key performance indicators with commensurate targets for health authorities and obligations of government; and
    - up to 50 broad health information measures to enhance reporting to government. These information measures would reflect ongoing health delivery operations that government requires in order to monitor the health of Albertans.

Recommendation 2.2

Better use of resources overall

Alberta Health and Wellness should report annually on each health authority's compliance with the terms and conditions of their contract and the Auditor General should review contract compliance.

Recommendation 2.3

Better use of resources overall | Overall improved service to Albertans

Contracts should include appropriate remedies and incentives that could be employed in a balanced and equitable manner.

Recommendation 2.4

Better use of resources overall | Overall improved service to Albertans

The Health Utilization and Outcomes Commission has been given the responsibility for measuring health outcomes and should do so for health outcomes expected under performance contracts. The Commission's objectivity is important and it should therefore function at arms length from both parties.

Recommendation 2.5

Better use of resources overall

The following principles and assumptions should form the basis of performance contracts.

a. Performance contracts would replace the existing business planning process as the method for government to approve the three-year operating plans of health authorities.

b. Health authorities will provide relevant and pertinent information to the Minister to enable the discharge of ministerial responsibilities to Albertans.

c. Health authorities should continue to prepare business or enterprise plans to guide their operations, act as management tools and reinforce public accountability.

d. Performance contracts will represent the mutual expectations and obligations of health authorities and government.

e. Performance contracts will have performance expectations that are factual, measurable, reportable and achievable.

f. Due to differences among health authorities, the contract framework will need to be flexible enough to recognize variances in service delivery that meet local needs.

g. Expected deliverables will facilitate health authorities' overall responsibility to ensure a system of health services for Albertans.

h. The administrative processes of performance contracts should be easily implemented, and should not place undue administrative burden on health authorities.

i. The initial contract term would be for three years, effective April 1, 2003. A performance contract could be re-opened upon the mutual agreement of both parties. Timeframes for contract renewal should be included in the performance contract.

j. The Government of Alberta will continue to set the funding framework.

k. The contract would be based upon predictable levels of service, funding and expenditures.

l. Incentives to meet or exceed stated expectations would be explicit within the performance contract, as would remedies for failing to meet the stated expectations of either party.

m. An independent third party will audit compliance with the terms of the contract and the results publicly reported, including review and scrutiny by the Provincial Auditor General.

n. There would be a dispute resolution mechanism that would be defined in the performance contract. This could include a mediation process.

o. Performance contracts will be public documents.

Recommendation Will Lead To:

Better use of resources overall

Recommendation 2.6

The Committee is recommending four broad key deliverable categories in the performance contracts, including financial accountability, innovation and effective service delivery, patients and clients, and people and partners. Performance items, measurement areas, authority deliverables and ministerial commitments have been identified. Appendix One sets out the recommended framework. Measurement areas and deliverables reflect outputs – indicators of improvement or reform of health care delivery. Measurement areas are identified. However, in a number of cases, further details will be required.

Section Three:
Facilitating Collaboration and Developing New Models of Care

The health care system is changing rapidly in response to new technology, increasing demands placed on the system by a growing and aging population, and the efforts of health service providers and others to develop creative and innovative responses to the challenges.

Increasingly these innovations involve collaboration among authorities, but in many cases, the potential of these new models of care province-wide has not been maximized.

This report identifies a number of opportunities for collaboration and new models of care across several sectors of the health system. These initiatives have the potential to substantially alter health service delivery in ways that can improve the quality of care and make our health system more sustainable. These are only some of the ideas in the system and service providers must continue to be open to new ideas as they emerge.

Recommendation 5.3

Facilitate cooperation among regional health authorities and use evidence from performance contracts to assess the effectiveness and viability of regions on an ongoing basis.

A Framework for Reform, Premier's Advisory Council on Health, page 49

Recommendation 5.6

Implement new models of care including comprehensive primary health care, disease management and other comprehensive care approaches.

A Framework for Reform, Premier's Advisory Council on Health, page 50

Facilitating Collaboration

The concept behind regionalization is collaborative – health authorities were established in the mid 1990s to reduce duplication and better integrate acute care, continuing care, community and public health services. The result has been fewer barriers to care and more effective service delivery.

There are many examples of successful collaboration (see sidebar). Some collaboration has been system driven: highly specialized services used by Albertans from across the province are located in major centres managed by the Capital Health Authority and Calgary Health Region. Some collaboration arises from health's culture of sharing information and research, as regularly occurs when medical officers of health from across the province work together on population health initiatives.

Other collaborative efforts are operational, such as recent steps to purchase drugs centrally and the joint development of a province-wide recruitment web site, *www.healthjobs.ab.ca*, by human resource leaders from each health authority. As well, health authorities are conducting a comprehensive review of the feasibility of sharing business functions such as payroll and information technology support. Through this process they expect to identify the best opportunities to improve operational efficiency.

In 2000, chairs of the regional health authorities and provincial boards established important principles for collaboration and identified the factors and circumstances to be taken into consideration when making policy recommendations. The Committee on Collaboration and Innovation endorses this work, including the

emphasis on providing the most appropriate service to the public and the need for collaborative efforts to add value from a service, quality, patient access and/or economic perspective. For a complete listing of the principles established by the Council of Chairs of Health Authorities, see Appendix Two.

Collaboration, however, has its limits – a collaborative system may not be a rationalized or integrated system where the right services are delivered in the right locations at the right time to the right people. Achieving an integrated and rationalized health system will require efforts beyond collaboration, including a health framework that begins to inform health providers – and Albertans – what services can be reasonably expected to be delivered by which jurisdiction in what location. This leads to an additional caution: A rationalized system can cost-effectively offer better service and transparent guidelines concerning access. It may not deliver more choice to Albertans or competition within the system.

Examples of Collaboration

There are many excellent examples of collaboration among health authorities. Some are long-standing while others are relatively new. The following examples, which may cite specific health authorities, are often mirrored in other areas of the province.

- Regional health authorities have jointly established a pharmaceutical purchasing group and the first requests for proposals closed June 21, 2002.
- Health authorities in northern and southern Alberta have established purchasing alliances to save time and money, and similar alliances have formed elsewhere.
- Capital and Calgary provide access to specialty clinics such as geriatrics, rehabilitation, ophthalmology and dermatology to health authorities across Alberta via telehealth technology.
- Telehealth technology also provides access to educational opportunities, such as medical grand rounds and nursing best practice rounds in the teaching hospitals, to physicians and staff across the province.
- Tele-ultrasound projects are underway across Alberta; tests are performed locally and data sent electronically to urban centres for interpretation.
- Capital Health Authority and the Alberta Cancer Board have established a virtual lung clinic to serve northern and central Alberta.
- Health authorities collaborate to better use skilled professionals in high demand and short supply. For example, two smaller regions share a medical officer of health; another two have shared a regional medical director.
- Outlying regions receive visiting specialist services from Calgary and Capital in the areas of urology, ENT, gynecology, gerontology, orthopedic surgery, ophthalmology, internal medicine, and developmental pediatrics.
- Mistahia and Peace health authorities now utilize HEALTHLink, the health advice line launched by Capital Health, and work underway will extend the program across the province.
- An inter-regional system has improved the transition of patients residing outside the Edmonton area who are discharged from Capital to their home region.
- The Critical Care Line provides a 24/7 direct phone link for physicians from other regions, provinces and territories to obtain stabilization advice and make transportation arrangements for acutely ill and injured patients.
- A province-wide recruitment web site has been launched, ***www.healthjobs.ab.ca*** which includes job postings, bulletins and information on working in different health professions.

Joint Programming and Cross-Boundary Service Delivery

More joint programming and boundary-free service delivery can occur. However, efforts have been hampered by the lack of clear guidelines for service delivery, including definitions of adequate access and determinations of how far anyone should have to travel to receive specific services.

Not having these guidelines makes it difficult for health authorities to determine effective collaborative initiatives between regions. It can also hamper the ability of a single health authority to encourage collaboration within its boundaries, often because of local concerns with a loss of service that are not offset by clear guidelines for acceptable service delivery.

Other less obvious areas for collaboration should also be explored. Government currently funds other 'people' services such as Children's Services and Persons with Developmental Disabilities on a regional basis. Health authorities could look at collaborating with other publicly funded providers to help ensure the best use of public funds.

A New, Collaborative Model for Trauma Care

Capital and Calgary health regions are jointly proposing a provincial trauma system for Alberta. The system would be based on Trauma Association of Canada performance standards for:

- tertiary trauma care (Calgary and Edmonton);
- regional trauma care sites in Lethbridge, Medicine Hat, Red Deer, Grande Prairie, Fort McMurray; and
- rural trauma centres.

Research and evidence says trauma systems can reduce morbidity and mortality from injury. The objective of this model is to provide all injured Albertans, including the severely injured, with the right treatment at the right trauma facility in the shortest time. The proposed framework will set expectations for transport and access times. Its components include:

- pre-hospital, hospital, and rehabilitation protocols and care maps;
- prevention and education strategies; and
- data collection through a single provincial trauma registry.

The proposal currently has the support of the two regions and will be advanced to Alberta Health and Wellness and other regions for support. The intent is to pilot and evaluate one regional site, then incrementally develop all regional trauma care sites.

Recommendations

Recommendation Will Lead To:

Recommendation 3.1

Health authorities and Alberta Health and Wellness should work together to set service standards and define access. The framework and protocols that are developed should accommodate communities of varying size and geographical distribution. Access, appropriateness, patient safety and effectiveness should be used as guiding principles. The process should begin before the end of 2002.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 3.2

Work should continue on the development of a provincial trauma system.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.3

Alberta needs a rural health strategy. This is important from both a health and economic standpoint. Alberta Health and Wellness and health authorities should work with stakeholders to develop that strategy, using the findings of the Rural Health Forum held in Red Deer on June 26 and 27, 2002.

Better use of resources overall

Recommendation 3.4

Patient transport services need to be better integrated with health authorities. This would help match services with local health priorities, address local concerns, and rationalize services. The situation was assessed during the MLA Review of Ambulance Service Delivery 2001. Determinations that will address the issues should be made.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.5

A single provincial drug formulary (list of approved drugs) should be developed by Alberta Health and Wellness, health authorities and continuing care centres. A single formulary for drugs on the schedule of drug benefits and those drugs provided in a facility would further the benefits of the joint purchasing initiative health authorities have underway.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 3.6

Government should establish a Collaboration Fund to invest in innovative ideas for collaboration and encourage creativity.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.7

Health authorities should pool resources in the areas of human resources, financial services and other business supports, such as payroll and purchasing, including shared service models.

Overall Cost Savings | Better use of resources overall

Recommendation 3.8

Health authorities should collaborate with other government-funded entities to maximize the use of public funds, including Persons with Developmental Disabilities boards, Children's Services authorities, senior's boards and lodge foundations.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Information Technology

Alberta is a leader in the use of technology in health care, yet much remains to be done.

Some of the barriers include the following:

- While there are many common definitions, common standards aren't used in every part of the health system. This can undermine confidence in the quality of information and makes comparisons difficult.
- Many systems in use today were designed before regionalization, which can mean separate systems for areas like home care and acute care. This can hamper information sharing within regions.
- Every health authority pays for its own information technology, which meets local needs but may not enhance compatibility between regions.

Efforts have been made to address these barriers and challenges. They include the following:

- Alberta Wellnet has built a "Gateway" that allows information to be exchanged between regions, provincially, and inter-provincially.
- The Pharmaceutical Information Network (PIN) developed through Wellnet will link together physicians in the community, pharmacists, hospitals and other authorized health care providers. PIN will have confidential access to patient medication histories, decision-support tools for prescribing and dispensing, and enable electronic prescriptions.
- Wellnet's Common Opportunity Initiative helps health authorities jointly purchase information systems and has reduced the number of different systems.
- Alberta Health and Wellness has recently established an Information Management - Information Technology Governance Council to identify and drive change. The Council will oversee investment in shared technology projects and determine priorities in the broad health sector. It includes strong representation from health authorities and other stakeholders.
- Physician Office Systems Program is a voluntary initiative jointly funded by Alberta Health and Wellness and the Alberta Medical Association to support the introduction of information technology in physician offices, including electronic health records, on-line professional development, and knowledge and practice management.
- The Alberta Supernet project will provide broadband access to all communities across the province, including health providers and health authorities. This far-reaching initiative will provide the infrastructure to support important new uses of technology in the health system.

Examples of New Models of Care and Improved Service Delivery Using Technology

Telehealth

Telehealth is the use of communications and information technology to deliver health and health care services and information over long and short distances [***Sector Competitiveness Framework of the Telehealth Industry***, Industry Canada (1998).]. Telehealth improves access and increases service efficiency. Telehealth uses include clinical consulting (tele-psychiatry), imaging (tele-ultrasound), homecare (tele-monitoring), learning and administration.

Alberta has one of the best provincial systems of telehealth, funded by Alberta Wellnet and fully interoperable among all health authorities, First Nations, and the Inuit Health Branch, with over 200 distinct sites in the province. Alberta Supernet will increase telehealth's access and capacity.

Telehealth models include the following:

- Advances in remote diagnostic imaging help the whole diagnostic imaging system move forward. By enabling images to be shared among a variety of providers, patient triage and management throughout the system would be facilitated. This image sharing requires a digital equipment base. The current inventory of imaging equipment in the province is a mix of digital and analog technology and will need to be upgraded to digital/PACS (Picture Archiving and Communication System).

- Tele-ultrasound is increasingly used to significantly improve timely and cost effective access to ultrasound services for patients outside of major urban areas. Patients receive their test within their community with the images read by radiologists at another location. This is an effective use of both ultrasound technicians and radiologists, both currently in short supply. Patient and provider satisfaction is very high with this new model.
- Tele monitoring expands, enhances and improves access to homecare services. By using electronic technology via a telephone line, nurses can provide cost-effective consultations to clients in their own homes. This is particularly effective in sparsely populated and geographically isolated regions.

Alberta HEALTHLink

HEALTHLink was launched by Capital Health in 2000, establishing the first comprehensive health advice and information service in Alberta.

HEALTHLink is staffed by registered nurses twenty-four hours a day, seven days a week. These nurses have an average of fifteen years of professional experience.

Roughly 90% of callers have subsequently felt able to make a necessary decision about their health care situation. Moreover, nearly one-half of callers said they were able to resolve their health problem without a physician visit they would have otherwise undertaken. Non-emergency visits to emergency wards have been reduced.

Already serving Mistahia and Peace health regions, HEALTHLink will be available province-wide in the next fiscal year, linking up with a similar service being established in Calgary. Other developments will include a "multi-channel" contact centre service with programs and services available on the web for access by the public and the ability to link the telephone service to the electronic health record. Enhanced services will be available for special populations, after-hour physician "call sign out", and chronic disease management.

Critical Care Line

Physicians, especially in rural areas, require timely access to expert advice and assistance. The Critical Care Line provided by the Capital Health Authority creates a single, timely point of entry to the necessary services.

Once a patient's critical care needs have been determined in rural or other areas outside Capital Health Region, a 1-800 call links the caller with Capital Health specialist(s) and other parties (e.g., flight physician). The relevant transport providers are incorporated as needed. This coordination and continuity of care provides a seamless transition for patients in areas outside Capital who require specialized services only available in the larger region.

Electronic Lab Results

As more physician offices become automated and electronic health records become the norm, other system efficiencies will emerge. An example of technology both driving and enabling change is the success Chinook Health Region has had in collaborating with local physicians in the delivery of electronic lab results around the region. Capital Health launched a similar electronic lab results project in June 2002, where all physicians in the region using electronic health records can now import lab results into patient records, as can physicians in the Alberta Cancer Board, Crossroads Health Region and Slave Lake Clinic in Keeweetinok Lakes Health Region. As well, physicians across the province will soon be able to receive their results electronically from the Provincial Laboratory. These projects are making lab results available faster, with less chance of them not being on hand when required.

Recommendations

Recommendation Will Lead To:

Recommendation 3.9

A single, three-year, health system strategic information management/information technology plan should be developed that sets out practical and tactical steps to get Alberta's health system connected in a meaningful way. The plan needs to move the system in the right direction and get decisions made and money flowing. It must also have effective evaluation mechanisms so adjustments can be made to ensure that the right outcomes are achieved.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

The plan should:

- make electronic health records a high priority;
- clearly identify the opportunities and next steps required to develop effective management information systems and clinical and workforce information systems; and
- take a business case approach to drive good investment decisions.

Recommendation 3.10

Developing common standards and getting the agreement and commitment by all stakeholders to adopt and support those standards should be a priority. Key projects can be used to develop information exchange standards.

Overall Cost Savings | Overall improved service to Albertans

Recommendation 3.11

The Information Management/Information Technology Governance Council should encourage system-wide progress in embracing and advancing the use of technology in new models of care and monitor and evaluate the success of technology adoption.

Better use of resources overall

Recommendation 3.12

The Health Utilization and Outcomes Commission should monitor and evaluate improved access and outcomes enabled by technology, including the effectiveness of new technologies.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.13

Health authorities should take the lead in working with stakeholders to develop a framework to guide imaging services at regional and provincial levels. This would help decision making around investments in picture archiving and communication systems (PACS), technology that would make it possible to share images electronically and facilitate collaboration among regions. This upgrading of systems and equipment should be a priority.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.14

Alberta Health and Wellness and health authorities should partner with Canada Health Infoway and ensure that work done in Alberta references the need for national health information. This will help develop electronic health records.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Human Resources and Expanded Scope of Practice

Shortages of health care professionals are a serious concern in the health sector. These make it critical that Alberta excel in training and recruitment initiatives and develop good human resource strategies. Shortages also provide the incentive and opportunity to explore the potential benefits of changing the scope of services that a variety of health professionals provide.

Substantial opportunities exist for delivering services differently in primary health care, palliative care, acute care and other community based services, including the use of multi-disciplinary teams. Nurse practitioners, licensed practical nurses, midwives, and others could provide a wider range of health services, reducing wait times and pressure on acute care hospitals and increasing access. Expanding scopes of practice to better use the skills of people in the health system is critical, but with it come changes to the way people have worked throughout their career and to the role the public expects them to play. Change management strategies will be important.

Health authorities work together on human resource issues, including province-wide bargaining, joint physician recruitment and a provincial recruitment web site. However, a persistent barrier to successful collaboration is a lack of consistent or complete information to underpin labour strategies.

Another barrier is the absence of a strategic long-term focus for human resource management in the health sector. Workforce management has been closely tied to funding: People are hired to meet rising demands and then laid off when budgets are tight. While understandable — about 70 per cent of authority funding goes to payroll — this practice has left the health sector with a legacy of morale issues and shortages of skilled workers when funding increases.

Examples of New Scope of Practice Models

Immunization by Licensed Practical Nurses (LPNs)

Alberta has one of the best immunization programs in Canada. However, the increasing number of new vaccines has increased the time spent by public health nurses on immunization. Licensed practical nurses can safely perform immunizations with registered nurse supervision, allowing both professions to work at full scope of practice and giving public health nurses more time to spend on health promotion/disease prevention and community development.

Direct Patient Care by Nurse Practitioners (NPs)

Nurse practitioners can provide comprehensive direct patient care as a central member of the health care team. In community settings they can work in primary health care clinics, continuing care settings, community agencies, physician offices or interdisciplinary health care clinics. Nurse practitioners could provide the core primary health care services, with physicians functioning in a consulting role - the right care at the right time and using the skill sets of each to maximum advantage. Nurse practitioners can also work in hospital settings including hospital care teams, specialized care units (renal care, critical care for adults and children, transplantation, etc.) and outreach programs such as seniors' health.

Medication Administration by LPNs

LPNs have the education and training to administer medications, freeing registered nurses to focus on other patient care duties within their scope of practice. In pilot projects, LPN medication administration helped improve patient care in acute care, long-term care and designated assisted living.

Pharmacists

Pharmacists have significant education, training and expertise to prescribe drugs once a physician or other qualified health care professional has made a diagnosis. In some cases, as is currently done for non-prescription drugs kept behind the counter, a pharmacist may assess a patient and prescribe.

Recommendation Will Lead To:

Recommendation 3.15

Changes must occur to scope of practice regulations to ensure that health professionals can fully utilize their skills, education, training and expertise. This work is underway and must be a priority.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 3.16

Once International Medical Graduates have gone through the training and assessment provided by the regions and qualified, health authorities should actively retain them to perform clinical duties in areas where there are shortages of acute care coverage.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.17

Health authorities need to examine their staffing mix and management practices in order to utilize registered nurses and licensed practical nurses. As well, legislative changes must occur to remove barriers and ensure that the staffing mix can change as care needs evolve, particularly in continuing care settings.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 3.18

Health authorities should jointly develop an overall human resources plan that is proactive, forward-looking and sustainable. This 'people plan' would complement and underpin the provincial workforce planning underway. It should include the means to share information on supply and demand, establish clear recruitment objectives and facilitate collaboration on professional development and training.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 3.19

Health authorities should develop human resource information systems with common measurement tools that gather the information needed to systematically analyze workforce needs.

Overall Cost Savings | Better use of resources overall

Data providing a common definition and categories of a full-time equivalent (FTE) employee along with well defined payroll costs would allow authorities to:

- more readily analyze compensation costs such as overtime;
- compare information about utilization of various health professions in different settings; and
- benchmark those costs and utilization patterns with other health care employers.

Continuing Care

In 1999, the Long Term Care Review Policy Advisory Committee released a landmark report entitled Healthy Aging: New Directions for Care. Commonly referred to as the Broda Report, it set out leading edge directions for healthy aging and continuing care, including an emphasis on flexible and responsive health care, and care options to permit Albertans to live as independently as possible as an alternative to institutionalization.

The Broda Report's recommendations have been accepted and some are being implemented, but not in standardized ways. Each health region has developed a 10-year continuing care service plan. Changes have been made to home care delivery, public health initiatives and housing programs. Health authorities are now providing more support to lodge residents, allowing residents to maintain their independence longer, rather than being moved into long-term care facilities.

A wider range of living options is being developed, including more 'aging in place' and supportive housing. These initiatives lend themselves well to collaborative ventures among health authorities, as well as partnerships with private and public sector organizations and agencies.

However, barriers to implementation remain:

- Health authorities can only use capital dollars for long-term care beds. Investment in assisted living options that might better meet the needs of people living in their region is prohibited.

Examples of New Continuing Care Models

The Broda Report proposed a continuing care framework with three streams: home living; supported living where home care and other health services are delivered; and facility-based accommodation.

In the first two streams, seniors would live in single dwellings or apartments, senior's complexes, group homes, seniors lodges, enhanced lodges or assisted living facilities, and receive services that help them stay healthy. Many supportive living models are being implemented throughout Alberta as new models of care and Alberta is seen to be leading the country in this area.

In the latter stream, the "facilities" would include nursing homes, auxiliary hospitals and other long-term care facilities. Broda Report recommended that in future, long-term care facilities should focus on providing services to those with high and complex health needs, leaving clients with other health needs to be served in the community.

The provincial curriculum and core competencies developed for personal care and home care attendants and the expanded scope of practice for LPNs support the implementation of this "aging in place" strategy as well as the development of new models for care.

- Designated Assisted Living (DAL) and Block Funded Home Care (enhanced lodges) are supportive living options that have been successfully implemented in some seniors' housing complexes. An evaluation of DAL indicated increased independence and a high degree of satisfaction by residents and families. Residents of continuing care centres are successfully being transferred to these lower cost and more appropriate options.
- Smaller residential environments in rural and urban settings can be used as an alternative to larger continuing care centres. An example would be homes/personal care homes serving up to 10 residents and staffed on a 24/7 basis with personal care attendants or LPNs.
- A campus concept of care with the continuing care centre in close proximity to the supportive living site promotes 'aging in place'. It also creates opportunities for restaurant or meal services, housecleaning, and other support services to be more efficiently utilized.
- Home Care Teams linked to on-call physicians can provide earlier intervention as problems arise and limit visits to the emergency department for the home care client.
- The provincial curriculum for personal care attendants and the expanded scope of practice for LPNs support the newer models.

- Provisions in collective agreements restrict the ability of health authorities to staff in the most cost-effective manner while still ensuring patient safety. They also make it difficult to change long-term care beds to assisted living settings where the change would better meet local needs.

- Alberta Senior's funding and grants go to seniors groups and lodges for housing and programming (housing is that department's responsibility). These local initiatives may not always be aligned with the needs identified by health authorities. This has occurred despite efforts to coordinate activities, including a requirement by Alberta Seniors that Healthy Aging in Place Initiatives funded in 2001-02 have service agreements with the appropriate health authority.
- Issues remain around charging for continuing care services. These are delivered in long-term care facilities, in the home and in lodges, assisted living centres and group homes, with a range of charges and ways of calculating fees. The Broda Report recommended the adoption of consistent principles and a framework to guide what should be subject to charges and what should be paid for by the health system.
- Accommodation charges in long-term care centres are heavily subsidized by the Alberta Government and can be an incentive for choosing long-term care, when other living options may be more cost-effective for the system as a whole and better for the individual.

Recommendation Will Lead To:

Recommendation 3.20

The Broda Committee should be asked to evaluate the degree to which its report has been implemented.

Evaluative recommendation – not rated.

Recommendation 3.21

Alberta Health and Wellness should revise the fee structure for all care options to ensure fairness and generate revenues that can be put back into services. For example, it shouldn't be less costly to live in a long-term care centre than an enhanced lodge.

Overall Cost Savings

Overall improved service to Albertans

The Broda Report recommended a conceptual framework for covering the costs of continuing care that outlined different obligations for various cost components.

- Clinical and therapeutic services performed by health professionals should be available without charge in all settings, as they wouldn't be subject to a separate charge if they were provided in an acute care setting.
- Assistance for daily living services is provided both by agencies and families and spouses. Therefore, these services should be cost-shared between public funding and individuals.
- Individuals are generally responsible for paying their own housing expenses, therefore, residents living in long-term care centres should be responsible for room and board costs, much as they would be for paying for their housing if they were living elsewhere. The Broda Report also said that charges for continuing care centres should be increased within the range of a minimum and maximum threshold amount, ensuring that subsidies are in place for those who cannot afford the higher fee levels.
- Income testing should be in place to allow public funding to provide assistance according to people's ability to pay.

This framework should be revisited, modified as necessary and implemented. The Alberta Seniors Benefit provides the safety net that ensures low-income seniors can continue to access the services they require.

Recommendation 3.22

Legislative and policy changes should be made to ensure that long-term care beds and facilities can be transformed into assisted living settings, including those necessary to ensure that these new settings are staffed in the most appropriate and cost-effective manner.

Overall Cost Savings

Better use of resources overall

Overall improved service to Albertans

Recommendation 3.23

Provincial capital grants available to health authorities are currently restricted to conventional continuing care beds. This barrier should be removed to allow for more innovative housing projects that recognize the need for alternatives.

Overall Cost Savings

Better use of resources overall

Overall improved service to Albertans

Primary Health Care Models

Primary health care is increasingly recognized by health care providers and sought after by the general public as a better way of keeping people healthy and making our health system more accessible and sustainable.

Primary health care includes the following key elements:

- 24 hour access to health advice, information, and services to help people make appropriate decisions to improve and sustain their health.
- Ready access to a broad range of basic assessment and treatment services in the community.
- Care by a multi-disciplinary team of service providers, who work together to help people maintain good health, avoid illness and injury, and provide effective treatment in the least-intrusive way by the right service provider.
- Health services that are linked and coordinated with other community services, including schools, children's services, seniors centres, etc. to support people in their communities.
- Referral to more specialized treatment when required, with streamlined and coordinated discharge planning to support people as they return to good health.

Examples of Primary Health Care Initiatives

The experience from work on pilot projects and other initiatives provides the basis for moving forward and considerable potential exists for significant improvements in health outcomes. These areas include the following:

- Disease Management, including better outreach and monitoring to ensure medication to manage conditions like asthma and diabetes.
- Multi-disciplinary community health centres, which provide comprehensive assessment and treatment of common health problems, explanation, guidance and direction for managing their health and referral to more specialized care when needed.
- 24-hour health advice and information lines staffed by health professionals to help people make decisions about their health and using the health system appropriately when necessary. In Alberta, HEALTHLink will be available province-wide in the next fiscal year and work is underway to expand its services through web-based enhancements. This opens up new ways of providing primary care, including:
  - helping manage chronic diseases through better monitoring and access to information;
  - linking people to the closest and most appropriate education using resources (e.g. diabetic classes) and or support groups; and
  - using best practice guidelines, HEALTHLink nurses can support individuals with chronic diseases and their family physician by routinely calling the client to ensure adequate follow-up.
- Day care for seniors, which allows health providers to monitor the health of participants and treat some health problems, provides social and recreational activities, and promotes nutrition and physical activity.
- Identification, treatment and follow-up for at risk populations for patients in an emergency department. Using a health risk appraisal software tool, nurses identify risk factors in high-risk patients (problem drinkers and IV drug users, smokers, women at risk for cervical cancer, etc.) in an emergency department and arrange for appropriate referrals.
- Healthy Families is an intensive home visitation program for high-risk families at the time of birth. This multi-sector partnership ensures families have appropriate access to health services, family support and other essential services to maximize the potential for physical and cognitive development.

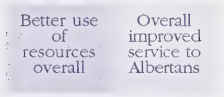
Since the mid-90s, Alberta Health and Wellness has funded primary care initiatives through the Health Transition Fund and the Innovation Fund. Considerable expertise has been gained but the potential of these initiatives has not been capitalized on.

In order to promote new developments in primary health care, Alberta Health and Wellness developed a discussion paper entitled "Advancing Primary Health Care in Alberta", and initiated consultation sessions with stakeholders across the province in the early summer of 2002. Once the input has been analyzed, it will be time to move forward and build on what Alberta already has learned about implementing primary care.

Recommendations

Recommendation Will Lead To:

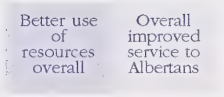
Recommendation 3.24



Alternative payment plans and primary care contracts will be critical to making primary health care reform happen. Contract negotiations between Alberta Health and Wellness and the Alberta Medical Association will be underway Fall 2002, with health authorities as full participants. Through those negotiations and in their daily work with each other, physicians and health authorities will be exploring new territory in their relationships. Alberta is in a transition phase when it comes to primary care and during this period:

- health authorities, physicians and other stakeholders will need to work together to identify regional priorities and develop new models of care;
- physicians and other providers will have to organize themselves to contract with health authorities; and
- Alberta Health and Wellness will need to ensure that the transition takes place.

Recommendation 3.25



Health authorities should develop primary health care centres and services, as well as networks of primary care physicians and other providers. This will build the health community's capacity to provide primary care services and encourage multi-disciplinary initiatives. Health regions have a responsibility to develop the markets for these services and encourage the formation of groups of providers.

Recommendation 3.26

Resources should be directed to managing chronic diseases that impact large portions of our populations, such as heart disease, asthma and diabetes. Managing chronic conditions through the use of integrated approaches, such as patient education and follow-up, can decrease use of other health resources (emergency and hospital days).

Recommendation Will Lead To:

Recommendation 3.27

Encouraging healthy lifestyle choices is an important population health strategy. Alberta Health and Wellness and health authorities should target three to five areas and work together with federal and municipal levels of government and the private sector to develop and implement programs such as tobacco use reduction, initiatives to deal with childhood obesity, injury prevention programs, "Safer Communities" initiative, etc.

Overall Cost Savings	Better use of resources overall

Recommendation 3.28

Developing HEALTHLink to its full potential as a source of health advice, chronic disease management tool and way of helping physicians manage on-call requirements should be a health system priority.

Overall Cost Savings	Better use of resources overall	Overall improved service to Albertans

Acute Care

Stronger links between community and facility-based care have led to new and innovative acute care models. Primary health reform will increase the need for new ways to support health professionals in delivering services, and for ensuring that the right services are in the right places so that people can receive the care they need.

The Committee has recommended that service standards be set and access defined (Recommendation 3.1). The new models being recommended here will help facilitate and rationalize hospital services when that framework is in place and determinations made on what needs to be provided in communities of varying sizes and geographical distribution.

New Ways of Organizing and Delivering Acute Care

Acute Recovery Services

At this time, patients receiving complex treatment in major hospitals stay in expensive tertiary/complex secondary specialty beds during post-operative and post-acute phases of treatment. While protocols exist now for discharging patients from tertiary/complex secondary care to their regions, patients could be transferred sooner if specialized acute recovery services were developed in some smaller or rural acute sites.

These specialized services would have standardized treatment protocols in place for recovery and rehabilitation, which could include best practice care maps such as the four-region pilot underway for community acquired pneumonia. Telehealth would allow complex patient discharges to be video-conferenced so caregivers as well as physicians could provide ongoing advice and support, as well as facilitating ongoing specialist consultation if required. These acute recovery services could be within the same region as the complex treatment or developed in other regions.

Inpatient Physician Teams

Inpatient physician teams (IPTs) or hospitalists are being used more and more as a way of providing hospital-based medical services when patients don't have a family physician or their physician doesn't have hospital privileges. These teams have the potential to reduce average lengths of stay, help non-acute patients move to more appropriate settings and improve access to primary care in the community, as primary care physicians have to spend less time completing patient rounds and hospital records.

This model, over time and for certain hospitals, can be expanded to include specialist physicians in core services. This could create service advantages as well as overcome on-call difficulties faced by hospitals.

Hospital Care Teams

Hospital care teams are modeled on the inpatient physician team concept. The concept has nurse practitioners working in acute care hospitals and collaborating with family physicians based in the community.

This new approach allows the family physician to focus on a community practice where they're needed to provide the public with timely and appropriate access to primary health care and integrates nurse practitioners into acute care. By working with the nurse practitioner, a family physician can maintain close contact with the hospital, supporting their patient and other health providers, but is not required to spend hours a day doing rounds.

Recommendation Will Lead To:

Recommendation 3.29

Regions providing complex services should stimulate the development of standardized acute recovery services by issuing a call for proposals.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.30

Health authorities should encourage the use of Inpatient Physician Teams (IPTs) to provide hospital-based medical services and look for opportunities to extend the model to include physicians in specialties like general medicine, pediatrics and obstetrics, helping overcome on-call difficulties experienced by hospitals.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.31

Health authorities should hire more advanced nurse practitioners and work with community-based family physicians to set up hospital care teams.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 3.32

New programs should be phased in to support short-term acute care drugs used at home. Patients who would otherwise have been admitted to hospital may find themselves being sent home with treatment plans and prescriptions for acute care drugs because of bed shortages, when the acuity of their condition makes it safe to do so. However, these patients are now required to purchase the drugs required for their treatment, whereas if they were admitted to hospital the drugs would have been funded by the health system. Health authorities are currently dealing with this issue on a region-by-region basis, with some covering the costs of those drugs, while others may not.

Better use of resources overall | Overall improved service to Albertans

Recommendation 3.33

The practice of medicine by physicians depends upon having access to health care facilities managed by health authorities. Health authorities and these physicians should be given the ability to contract directly with each other, rather than having to rely upon the fee-for-service model and ad hoc agreements.

This will allow the authorities and physicians to work out business arrangements that minimize the friction and frustration inherent in a system in which the two parties need one another yet do not have a formal relationship.

Better use of resources overall

Recommendation 3.34

There are health service providers in Alberta who currently access health authority services yet have no formal relationship with the health authority in question. To help achieve better health outcomes and system management, more formalized relationships should be established between health service providers and health authorities to support access to health system resources, such as laboratories and diagnostic imaging.

Better use of resources overall | Overall improved service to Albertans

Section Four:
Establishing Centres of Specialization

Recommendation 5.5

Encourage health authorities to develop centres of specialization.

A Framework for Reform, Premier's Advisory Council on Health, page 50

A centre of specialization is a place where an activity or service is concentrated as a result of a strategy for improved utilization and quality. At times, the term 'centre of specialization' has been used interchangeably with 'centre of excellence' but the two are not the same. Centres of excellence are national and international centres for leading-edge research and training, as well as patient care. The two centres of excellence for health care – cardiac and bone and joint care – announced by Alberta Health and Wellness in 2001 are good examples.

The recommendations of the Committee on Collaboration and Innovation focus on centres of specialization. These centres should be developed, yet some caution is advisable. As the guiding principles laid out in this report indicate, not all facilities or locales are suitable as centres of specialization. As well, centres of specialization may be efficient and effective service delivery mechanisms that result in greater quality, but they may also encourage monopolies and reduce choice. Finally, the term tends to conjure up traditional clinical applications but there may be tremendous opportunities in non-clinical areas, such as dietary/food service operations or other support services, and public health disciplines.

Doctors, other providers, communities and regions could all champion centres of specialization and encourage their development. However, each region will need to ensure that the plans fit with the needs identified in the region and in other regions before deciding if a centre should be pursued.

Guiding Principles for Centres of Specialization

Greater volumes mean greater expertise.

There is clear research evidence that patients treated in hospitals doing higher volumes of a particular procedure are less likely to have poor outcomes than patients from hospitals doing lower volumes of the same procedure. Sufficient numbers also are needed to attract and retain specialized health care teams, including physician specialists.

Centres of specialization are not achieved by new buildings or the latest equipment.

Buildings and equipment are important, but what really determines a centre of specialization is the available expertise of health service providers. Centres of specialization must be in communities that can attract and retain the right people.

Centres of specialization must address health system priorities.

Centres of specialization must be developed around priority areas that contribute to the overall health of Albertans.

Centres of specialization must be cost-effective.

A centre of specialization implies efficiency and cost-effectiveness. This is particularly important if a centre of specialization expects to market its services to other health authorities.

Centres of specialization can maximize the distribution of services.

Centres of specialization can be developed in rural facilities with itinerant physician expertise. Health authorities can work together to ensure better utilization of rural facilities and rationalized services that maximize benefits to each partner.

Centres of specialization require marketing and public education.

Health authorities that buy services from a centre of specialization in another region will need to let the public know that leaving their region for a specialized service in another region is to everyone's advantage.

Centres of specialization have to be balanced with the need to maintain expertise in teaching hospitals.

Centres of specialization could diminish the ability of specialists to do research, teach classes and provide training. This could have both short and long-term detrimental effects on the health system and should be an important consideration when centres are contemplated.

Centres of specialization will be evidenced-based and supporters of best practices.

Matching the programs of a centre of specialization to the best available elsewhere is fundamental to the concept of centres of specialization and will ensure accountability and enhance public confidence.

Centres of specialization will be externally validated.

Some form of an independent provincial advisory or consultative body that could review a proposal for a centre of specialization may be necessary to determine if the proposal meets the appropriate criteria.

Centres of specialization could increase access to necessary health services.

Centres of specialization, by the very nature of their efficiency, could create additional access to specialized services for Albertans.

Other considerations

Health authorities should take the following considerations into account when reviewing the possible development of a centre of specialization.

- Because of the number of patients and specialized personnel needed, few communities may actually be able to support a centre of specialization.
- Health authorities should develop business cases and use existing infrastructure in proposals for centres of specialization.
- If distances are too great, patients will resist the travel time and costs and it will be difficult to recruit expert health service providers.
- New uses of technology such as telehealth could overcome travel barriers and should be seriously considered as a component of any centre of specialization.

Recommendations

Recommendation Will Lead To:

Recommendation 4.1

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Regions considering a centre of specialization need to develop a detailed business case that addresses capital costs; staff recruitment, retention and training; and physician supply and expertise. Business cases should also address:

- the impact on other parts of the health system, including the viability of other programs offered by hospitals or health centres if the services to be offered by the centres of specialization are no longer provided in those facilities;
- the impact on teaching and research;
- necessary program supports such as diagnostic imaging and laboratory services;
- transportation costs;
- marketing strategies; and
- potential for revenue, both as part of marketing the centre to other health authorities as well as to local community groups and foundations.

Recommendation 4.2

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Health authorities should work collaboratively to identify high priority needs for centres of specialization, some of which may include Aboriginal health, stroke rehabilitation, seniors/geriatric programs, and brain injury.

Recommendation 4.3

Better use of resources overall | Overall improved service to Albertans

Incentives such as the proposed Collaboration Fund should be in place to encourage the development of centres of specialization and ensure that funding is not a barrier.

Section Five:
Contracting with a Blend of Providers

Purchasing services is not new to health care in Alberta. The practice has typically been based on historical precedents, such as laboratory and diagnostic services, care centres, home care, community physiotherapy and some support services.

Health authorities are both providers and purchasers. The Committee on Collaboration and Innovation believes that Alberta can achieve the desired ends – namely more choice, efficiency, effectiveness and innovation – without separating the roles of purchaser and provider. Instead, new ways of looking at service provision - shifting organizational culture to a purchaser perspective - will help authorities find new relationships and ways to deliver services.

Much if not all service purchase has been generally accepted. However, debate in 2000 around the Alberta Health Care Protection Act, which provided the framework for contracting surgical services, highlighted the need for the health system to balance legitimate but differing values around contract services.

The organizational challenges and significant resources required to move the system to one characterized by more choice and competition also need to be acknowledged. Realistic targets must be set at a time when health authorities and other providers are being asked to manage an enormous amount of change on top of their day-to-day responsibilities. This is not a reason to delay the transformation; it is an acknowledgement of the many initiatives being managed in the health system.

Recommendation 5.4

Encourage health authorities to contract with a wide variety of providers including other regions, clinics, private and not-for-profit providers and groups of health providers.

Recommendation 5.7

Encourage an innovative blend of public, private and not-for-profit organizations and facilities to deliver health care services.

Recommendation 5.8

Encourage groups of health care providers to establish care groups and offer a range of services to individuals and health authorities.

A Framework for Reform, Premier's Advisory Council on Health, page 50-52

Benefits of Contracting

There are a number of benefits to be realized through contracted services.

Focus

Contracting allows the purchasing agency to focus on core services.

Specialization

Provider agencies have often developed specialized expertise through repetition and volume, which can enhance efficiency, productivity and quality.

Flexibility and responsiveness

External service providers are often smaller organizations whose decision-making processes and relationships with their employees can be more flexible and responsive.

Cost-effectiveness

Specialization and flexibility often result in lower unit costs for service delivery than the contracting agency can achieve on its own. Additionally, competitive forces exerted by the market can further reduce costs.

Capital investment

The market generally has the ability to more easily access, or assemble, capital than the public sector.

Consumer orientation

Markets with the capability and capacity to provide consumer choice will encourage provider agencies to become more consumer and service focused.

Service risk management

A mix of providers lessens the risk of system-wide service disruptions.

Considerations when Contracting Services

Other factors should be considered when contracting health services.

Limited competition

Options are limited and benefits may be reduced when only a few competitors offer a contracted service.

Medical procedure complexity

Specifying and monitoring contracts can be complex when there are various "best ways" to provide a certain service.

Organizational disruption

The contracting process can consume significant resources and transfers have to be carefully planned to minimize service disruptions. Human resources can also be impacted, both during transition and after contracting out, particularly if there are shortages of qualified workers and real or perceived benefits to working in the contracted setting.

Institutional capacity

Regions need to ensure that they retain the expertise needed to monitor contract compliance and maintain service options.

Liability

Though most contractual arrangements are clear regarding liability, purchasers often maintain a "duty of care" that can't be delegated.

Reputation and public confidence

Similar to liability, many purchasers maintain an obligation to act in the public's interest and are seen by the public as being responsible for the effectiveness of the contracted service. If a service is not performed satisfactorily, it may damage the reputation of the purchaser in the eyes of the public.

High standby costs

The public system will likely maintain services that are difficult to purchase given their complexity – multiple trauma, for example. Under some circumstances or contracting scenarios, this could result in higher unit costs given the need to have these services available at any given time (standby costs).

The Public Interest

In the publicly funded health system, funding is a means to an end. The end, or objective, is the delivery of a comprehensive array of effective health services. The public health system is responsible for ensuring that services are high quality, that the right amounts of health services are available to provide reasonable access, and that services are delivered in a timely fashion. These factors are arguably at least as important as cost-effectiveness when making purchase/provide decisions -- health services should be contracted out only when the community is better served by doing so.

Cost Considerations

The types of costs that are relevant when choosing between providing a service or purchasing a service include the following.

Production costs

These costs include the operating and capital costs to provide the service. The purchase/provide decision should consider the incremental costs, as there are some fixed costs that cannot be avoided even though the service is contracted out.

Bargaining costs

Bargaining costs include:

- costs arising from negotiating contract details;
- costs to negotiate changes to the contract once it has started due to unforeseen circumstances;
- costs to monitor contract performance; and
- costs of contract disputes and resulting remedies, including termination and service transitioning.

Other costs can arise when responding to lobbying efforts that relate to contractual issues and the effort required to ensure all proposed changes to an agreement continue to honour the original intent.

Contracting Costs and Risks

There are generally three key factors when assessing the costs and risks of purchasing services: service complexity, current market capacity and asset specificity. These factors form a useful framework to assess contracting health services.

In general:

- the greater the service complexity, the greater the risk and cost of contracting out;
- the greater the asset specificity, the greater the risk and cost of contracting out; and
- all other things being equal, the more participants in the marketplace, the lower the cost and risk of contracting out.

One of the costs of contracting is workplace morale. Even a discussion on contracting out can have a significant negative impact on staff currently doing the job. As well, the high rate of unionization in the health sector adds complexity: Union relationships and contractual obligations have to be managed in any exploration of contracting options.

Encouraging Market Participation

As the Premier's Advisory Council on Health said, the health system is a monopoly.[3] If we want to encourage competition and choice, there need to be more participants in the marketplace to lower the potential costs and risks.

Markets respond to opportunity. Some thinking within health authorities is that if they test who can best provide a given service, they will create more opportunities and encourage new providers to enter the market. The Calgary Health Region, for example, has begun doing significant work on how to help its managers think like purchasers rather than providers.

The potential for competition in the marketplace will also vary depending on geographical location and population. While fewer alternatives may be present in less populated regions, opportunities still exist or could arise and should be pursued.

Providing opportunities alone, however, may not be sufficient. It may be necessary to help an entrepreneurial and innovative culture develop in the health system. It would seem that a base exists upon which to build. For example, many physicians manage their practice or share in a group practice, physiotherapists run private clinics, and pharmacists operate retail operations.

Principles for Provider Relationships

Health authorities have a legal requirement to govern the health system in a fair and equitable manner and to ensure the provision of health services to Albertans. As health authorities position themselves to develop new relationships with providers and explore new opportunities, a clear set of principles is required.

The following are offered as a starting point.

- The focus should be on the development of an integrated health system. Contracts should help coordinate health service delivery.
- Legitimate but differing interests exist between individuals, communities and population groups. These interests must be balanced with the need for equity, efficient service delivery and available resources.
- Health authorities have a duty to act in the public interest and must maintain their public stewardship role and fiduciary responsibility in their relationships.
- Providers should have a clear understanding of a health authority's vision, values and mission.
- There should be a clear understanding by all parties of the risk involved in all contractual arrangements and risk should be defined and assigned at the outset.
- Health authorities have an ongoing and legislated duty to ensure services are provided regardless of who is delivering the service.
- Health authorities and health service providers share a mutual obligation to protect the privacy and confidentiality of personal or proprietary information.

[3] *A Framework for Reform*, Premier's Advisory Council on Health, page 21.

Recommendations

Recommendation Will Lead To:

Recommendation 5.1

Health authorities should examine their services and determine how they can be delivered in the most cost-effective manner. 'Make or buy' decisions should be made to ensure that opportunities to expand the provider base are maximized.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 5.2

Health authorities need to determine what public/private provider mix offers the maximum service value and develop supporting strategies to diversify the service provider base.

Overall Cost Savings | Better use of resources overall | Overall improved service to Albertans

Recommendation 5.3

Alberta Health and Wellness should maximize opportunities to use the Medical Services Budget and other expenditures to encourage the development of new groups of health care providers and an innovative blend of public, private and not-for-profit organizations and facilities to deliver health care services.

Better use of resources overall | Overall improved service to Albertans

Appendix One:
Key Deliverables and Performance Measures Framework

Financial Accountability

Performance Item	Measurement Notes	Health Authority Deliverable	Government's Commitment
Balanced budget	No annual operating deficits except where specifically approved by the Minister. Defined funding for contract period.	Manages within available funds.	Provides three-year funding commitment, with provision for adjustment where inflation, population growth, technology and drug costs exceed an assumed rate.
Cost management strategies	Determination of instances where fees should be charged for services not covered by the *Canada Health Act*. Parameters of non-government funding to be defined.	Increased non-government revenue sources.	Remove potential legislative and policy barriers and provide supportive policy[4]. For example, the per diem charges for long-term care and charges for community rehabilitation.
Investment in capital equipment and technology	Expected average remaining useful life of capital equipment. Total operating and capital investment in technology as a percentage of total expenditure.	Evidence that appropriate investment is occurring from allocated funds and private funding.	Provides leadership, necessary support and regional coordination.
Costing of service	Patient-specific costing of all health authority services by a specified date.	Phased in costing of specific services on an annual basis.	Provides leadership, necessary support and regional coordination.

[4] The MLA Task Force on Health Care Funding and Revenue Generation is examining options for raising revenue for health regions. As well, the Expert Advisory Panel to Review Publicly Funded Health Services will be recommending what health services should be publicly funded and what others may be paid for by other means. The findings of both groups will be relevant in determining the parameters of non-government funding sources.

Innovation/Effective Service Delivery

Performance Item	Measurement Notes	Health Authority Deliverable	Government's Commitment
Wellness[5]	Level of investment made. Rate of population self-assessment. Adherence to plan. Program-related output.	Develop an action plan on healthy population that focuses on key areas including: • tobacco reduction initiatives; • measures to reduce childhood obesity; • measures to reduce incidence of diabetes and to minimize co-morbidities resulting from diabetes; and • other key focus areas as identified.	Develop goals, strategies and targets. Identify key focus areas.
Access to services[6]	Identified services are provided within 90 days (maximum). Wait list registry available to support guarantees. Wait list data are received in a timely manner, by health authority/physician/service type. Access to continuing care services. Public perception.	Identified services are provided within 90 days. Wait time data are provided as specified, with common definitions. Health authority makes wait list registry information available.	Lead the process to select services requiring 90-day guaranteed access. Coordinate the development and implementation of the Alberta Wait List Registry project. Specify the data elements required. Work with health authorities to determine appropriate wait times.
Access to hospital-based emergency services	Access standards for emergency services to patients to be defined.	Emergency services are available within defined time standards.	Lead the process to identify the requirement. Support the development of safety standards.
Mental health transition	Patients and clients (quality of care) People and partners (workforce satisfaction) Financial accountability	Establish mechanisms to measure patient/client satisfaction and staff/physician satisfaction. Identify funding needs to meet service requirements for mental health clients.	Remove legislative barriers and provide supportive policy and funding. Work with health authorities to develop a province-wide mental health services plan based on mental health need.

[5] Wellness strategies may not make a measurable difference for years i.e. the effectiveness of work with young children to reduce the number of them becoming smokers won't be measurable until adolescence and beyond.

[6] This performance item incorporates access to all services provided by health authorities – acute to community based care and primary care. The Committee recommends the development of a framework and protocols to determine core services, set service standards and define access. (see "Joint Programming and Cross-Boundary Service Delivery," page 21.).

Patients/Clients

Performance Item	Measurement Notes	Health Authority Deliverable	Government's Commitment
Extent of public and patient satisfaction on the quality of care. **Existence of measures to enforce safety standards.**	Quality of care and safety standards.	Implements appropriate strategies to enhance quality of care, improve level of public and patient satisfaction and enhance safety standards.	Provide appropriate guidelines on the specific dimensions of quality of health services and identify measures of safety.
Primary health care	Alternative care models in place.	Contact centres are established. Collaboration with other health authorities is evident. Alternative models of delivery are in place and each health authority will prioritize delivery models utilized accordingly to local service needs.	Support for alternative models is provided. Legislative barriers are removed.
Continuing care	Ratio of 'Broda' defined service streams.	Patients' service requirements are assessed before they are admitted for care. Evidence of a shift in the site of service delivery from long-term care to supportive housing and home care.	Legislative barriers are removed. Standards for delivery of services for sites are established.

People and Partners

Performance Item	Measurement Notes	Health Authority Deliverable	Government's Commitment
Workforce	Ratio of vacancies to staffed positions. Staff satisfaction rates. Standard definition of vacancies.	Evidence of short- and long-term workforce strategies in place. Health authorities collaborate to recruit all health professionals. Satisfactory staff morale. Implementation of centres of specialization that optimize workforce expertise.	Legislative barriers are removed. Develop policy and guidelines for practices and health professional ratios. Strategic manpower plan and coordination of supply side training of health professionals. Support to establish centres of specialization.
Government relationship	Information required by government is submitted by due date. Annual board evaluation submitted.	All required plans and documents are provided on time (financial statements, annual report, business plan, IT strategy, workforce plan, long-term care strategy, etc.). A structured process in place to ensure board self-assessment.	Timely provision of clear directives and deadlines. Work with health authorities to determine appropriate timelines.
Public-private partnership	Outcomes and extent of collaboration and joint ventures with the private and not-for-profit sector and groups of health providers to diversify the provider mix.	Engage in innovative partnership models that benefit the health system.	Legislative barriers are removed. Policy and framework developed.
Inter-regional collaboration	Extensive collaboration with other health regions.	Evidence of collaboration.	Flexible funding arrangements to encourage inter-regional collaboration.

Appendix Two:

Guiding Principles for Collaboration and Unique Factors for Consideration

In 2000, chairs of the regional health authorities and provincial boards established important principles for collaboration and identified the factors and circumstances to be taken into consideration when making policy recommendations. The Committee on Collaboration and Innovation endorses these principles and unique factors developed by the chairs, including the emphasis on providing the most appropriate service to the public and the need for collaborative efforts to add value from a service quality, patient access and/or economic perspective.

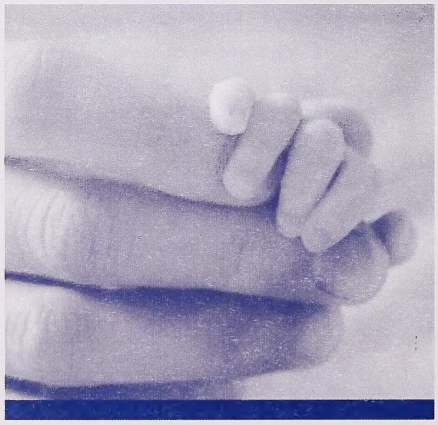
Principles

- Providing the most appropriate service to the public should be the primary consideration when planning health care service delivery models and structures.
- Joint service delivery initiatives should add value from a service quality, patient access and/or economic perspective.
- Regional health authority geographic boundaries should not impede patient access to good quality, cost-effective health care services.
- The unique needs and circumstances of individual health authorities should be considered carefully when making decisions that have province-wide implications.
- Joint service delivery initiatives should not necessarily require the participation of all health authorities. Some initiatives may involve a small number of health authorities; and health authorities should have the right to opt in or out.
- The unique strengths and program experience of participating health authorities should be recognized and built upon to support cooperative initiatives.
- High priority should be placed on maintaining open and honest communications, cooperative and productive working relationships, and developing trust among health authorities.
- The costs to provide joint services should be shared equitably and fairly among participating regions in relation to the range and level of services accessed.
- The roles and obligations of participating health authorities should be clearly defined.
- Funding processes should minimize disincentives to cooperation.

Factors and Circumstances

Unique factors and circumstances need to be taken into consideration when making policy recommendations that have province-wide implications. These can include the following:

- demographic composition of a health authority – including population size and density, age groupings, and unique population groups served;
- geographic characteristics, including the size of the area served and its distance from large urban centres;
- economic conditions, including cost of living, salary levels and housing availability;
- needs of unique populations served;
- range of service options and choices available;
- ability to attract and retain required health care employees;
- existence of private partners and their willingness to invest in certain communities; and
- financial capacity/resources of the health authority.



alberta
HEALTH FIRST